DEPARTMENT OF INLAND FISHERIES AND WILDLIFE

DISABILITY MEDICAL EVALUATION

PLEASE PRINT OR STAMP CLEARLY

PHYSICIAN'S NAME:_____

STREET ADDRESS OR BOX NUMBER: _____

CITY:_____ **STATE:**_____**ZIP CODE:**_____

AREA CODE:_____ **PHONE NUMBER:** _____

Patient's Name:_____

DATE OF PATIENT DIAGNOSIS:_____

1. IN "LAYMAN'S TERMS", PLEASE DESCRIBE THE NATURE/DIAGNOSIS OF IMPAIRMENT:

Please be specific about the patient's impairment. Describe only the impairment(s) that affect specific body functions needed to hunt, fish, or trap, such as exiting a motor vehicle; standing, balance, walking, or use of the arms; handling a firearm, bow and arrow, or other equipment; or properly identifying a target. For example, having a heart condition may not significantly impact the patient's ability to exit a motor vehicle and ability to walk a short distance to legally discharge a firearm.

_____

_____

_____

2. Is this a permanent condition? YES NO

IF NO, PLEASE INDICATE ANTICIPATED DURATION OF IMPAIRMENT.

_____

3. PLEASE DESCRIBE THE PATIENTS FUNCTIONAL LIMITATION(S) RELATED TO IMPORTANT BODY FUNCTIONS NEEDED TO HUNT, FISH OR TRAP.

Please state clearly the patient's functional limitations that impacts their ability to hunt, fish, or trap. For example, if the impairment affects the patients ability to hunt, please explain how the patient's functional limitations impact the essential functions of hunting, i.e., entering or exiting a vehicle; standing, balancing, walking, and use of the arms; handling a firearm, bow and arrow, or other equipment; properly identifying an animal; or tolerating cold weather. _____

_____

4. HOW SEVERE OR SUBSTANTIAL IS THIS FUNCTIONAL LIMITATION?_____

_____

5. IN YOUR OPINION, DOES THE IMPAIRMENT PREVENT THE PERSON FROM CARRYING OUT ESSENTIAL FUNCTIONS ASSOCIATED WITH HUNTING, FISHING, OR TRAPPING?

YES **NO**

If YES, Please explain:_____

_____

6. HAS THE PATIENT BEEN PRESCRIBED ANY OF THE FOLLOWING AMBULATORY DEVICE(S) ?

IF SO, TO WHAT EXTENT IS THE PATIENT REQUIRED TO USE THE DEVICE(S):

Full-time/ Part-Time/ Only under certain conditions. (Please explain below):

Wheelchair:
Canes: **State # of canes**_____
Walker:
Crutches **State # of crutches** _____
Other:

7. IF APPLICABLE: Does the patient's impairment prevent them from handling a firearm or bow and arrow without the aid of adaptive equipment? (i.e. involuntary muscle spasms, loss of strength in arms, range of motion, etc.) **Yes** **No**

IF YES, PLEASE EXPLAIN:_____

_____

_____

_____

I certify that the patient whose name appears on this application is currently under my care and has the impairment as stated.

_____

PHYSICIAN SIGNATURE DATE

RETURN APPLICATION TO:

Department of Inland Fisheries and Wildlife
Deputy Commissioner
41 State House Station,
Augusta, Maine 04333